General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Haria Chemists, 25 Friern Barnet Road, New Southgate, LONDON, N11 1NE

Pharmacy reference: 1040406

Type of pharmacy: Community

Date of inspection: 26/08/2021

Pharmacy context

The pharmacy is in a parade of shops at a busy road junction. It provides NHS and private prescription dispensing mainly to local residents. The team also dispenses medicines in multi-compartment compliance packs for some people. And the pharmacy provides treatment for drug service users.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.6	Standard not met	The pharmacy does not keep all its records in line with requirements
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not keep some of its medicines in a legally compliant way
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not keep all its records up to date, including some of those required by law. However members of the pharmacy team usually work to professional standards and identify and manage risks effectively. They discuss mistakes they make during the dispensing process between themselves. They understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by a trade group. The SOPs covered the services that the pharmacy offered. A sample of SOPs was chosen at random and these had been reviewed in 2018. They did not always reflect accurately the way services were provided in this pharmacy. The written procedures said the team members should log any mistakes they made which were corrected during the dispensing process in order to learn from them. Any mistakes that did occur were discussed in the team, but they were not recorded. Only the pharmacist dispensed medicines and then checked them himself. The SOPs also said that they would fill in the dispensed by and checked by boxes, but these were not filled in.

The pharmacy displayed the responsible pharmacist notice where it could be seen easily. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy had professional indemnity and public liability insurances in place.

The pharmacist recorded private prescriptions and emergency supplies on the computer but the details of the prescriber were not always recorded accurately. Instalment prescriptions for methadone were not marked at the time of supply. And the controlled drugs registers were not all kept correctly.

The pharmacist said that they tore up any confidential material before it was put into the bin. It was not possible during the inspection to verify that this protected sensitive information adequately; none was seen in the pharmacy and the commercial waste bin had been emptied that morning. There was a shredder in the pharmacy and using this would provide better assurance that all identifiable information is destroyed correctly. Computers and labelling printers were used in the pharmacy. Information produced by this equipment was not visible to people in the retail area. Computers were password protected to prevent unauthorised access to confidential information. Other patient-identifiable information was kept securely away from the public view. The pharmacist had undertaken safeguarding training and was able to access the local safeguarding contacts, if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just about enough staff to provide its services, and the team works effectively together and are supportive of one another. But the assistant has not completed the formal training now required by the GPhC to ensure they have the right skills and knowledge for their role.

Inspector's evidence

The pharmacy team consisted of the pharmacist and a pharmacy assistant, who worked on the pharmacy counter, serving customers and in the dispensary, putting stock away and sometimes getting out stock for prescriptions. They had been 'grandparented' when the first requirement for formal qualifications was introduced. However, there have been recent changes to training requirements for pharmacy support staff. The pharmacist said that he would enrol her on suitable courses immediately, and following the inspection he confirmed that he had enrolled her on a counter assistant's course. The assistant was given pharmacy magazines to read to help them keep up to date. But they said that, due to the pandemic, they had not done been able to find time to read the material for some time. The pharmacist and assistant discussed changes to medicines categories when changes were made to legal status, for example.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area in the shop. The pharmacy could do more to reduce clutter and manage waste appropriately.

Inspector's evidence

The pharmacy had level access from the pavement. It was spacious and there was lots of room for air to circulate. The pharmacy was limiting numbers of people in the shop to two customers at a time. The window had posters displayed giving information about the pandemic. The shop was clean, tidy and bright. There was a Perspex screen between the staff and the customers, to provide a barrier to reduce transmission of COVID-19. There was hand gel available for customers as they walked into the pharmacy. The large consultation room was not available for customers as it was currently being used for storage. But due to the relatively low numbers people coming to the pharmacy, it would be possible to have a private word with the pharmacist, when there was no-one else in the shop.

The dispensary was very cluttered, so there was limited space for dispensing prescriptions. There was a small space in the rear dispensary where multi-compartment compliance packs were dispensed. But it was not possible to stand close to this dispensing bench due to the boxes stored in the floor in front of it. The sink was also in the rear dispensary. Again, easy access to this was blocked by clutter. Waste was not always stored securely.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy doesn’t always make sure that its medicines are stored correctly. But it generally delivers its services in a safe and effective manner. And it gets its medicines from reputable sources. It tries to make sure that people have all the information they need so that they can use their medicines safely although there are times when this does not happen consistently, including those people who receive their medicines in multicompartment compliance packs.

Inspector's evidence

Computer-generated labels for dispensed medicines included relevant warnings. They were not initialled at the dispensing and checking stages as only the pharmacist dispensed and checked the items. This could make it harder to establish who had dispensed and checked each medicine if a locum pharmacist was involved in the process.

Prescriptions were dispensed by the pharmacist but the labels were produced without printing out the prescription, which meant that checking had to be done from the computer screen. Partially dispensed prescriptions were also left without a printed prescription, but with the labels already produced. The Pharmacist said that he always used the prescription on the computer screen to check medicines and labels. Prescriptions were handed to people by the pharmacist and he said that he counselled people about their medicines. It was not fully clear how prescriptions for higher-risk medicines would be identified so that people received the information they needed to take them safely. This was discussed with the pharmacist during the inspection. The pharmacist said that people in the at-risk group who were receiving prescriptions for valproate were usually counselled about pregnancy prevention. And appropriate warnings stickers were available for use if the manufacturer's packaging could not be used. Schedule 4 controlled drug prescriptions were not always highlighted to staff who were to hand them out. This could increase the chance of these items being given out more than 28 days after the date on the prescription.

Some people were being supplied their medicines in multi-compartment compliance packs. There was a summary sheet in the pharmacy for each person receiving these packs showing any changes to their medicines and where the medicines were to be placed in the packs. People would telephone the pharmacy to order their next supply of medicines, but the pharmacy had no audit of when the packs were due to be supplied. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs did not have tablet descriptions to identify the individual medicines contained in the packs and no patient information leaflets (PILs) were supplied. This meant that people could not easily identify the medicines or access the information provided by the manufacturer about their medicines.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. But some medicines were not always stored or recorded in line with legislation. There were markings on boxes to indicate items which were short dated. Regular date checking was done and no out-of-date medicines were found on the shelves. The fridge temperatures recorded showed that the medicines in the fridge had been consistently stored within the recommended range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use. It could make better use of the equipment it has by keeping it in a more accessible location.

Inspector's evidence

The pharmacy had a shredder which could have been used to destroy confidential waste. But it was in a cupboard under the sink and had items stored on top of it. So, it was not readily available to use.

The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross-contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination.

There were no waste bins in the pharmacy, the pharmacist said that they used cardboard boxes, but again there were none seen.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.